Report on
MEDICARE COMPLIANCE

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Weekly News and Compliance Strategies on CMS/OIG Regulations, Enforcement Actions and Audits

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Second CMS Appeals Settlement Process Will Start Dec. 1, Pays Hospitals Less

Hospitals that turned down CMS's 2014 appeals settlement have another shot on Dec. 1, but this time they will get less money — although it probably will come faster. CMS officials were a little opaque about the reason hospitals will receive 66% instead of 68% of the net allowable amount of denied patient-status claims in return for withdrawing appeals, but they indicated on a Nov. 16 call that it's the price hospitals pay for the "additional burden" of CMS taking on a second settlement process.

Like last time, the settlement process is available for denied claims that have a date of admission before Oct. 1, 2013, if the appeal is pending before an administrative law judge (ALJ) or the Medicare Appeals Council or the hospital has not yet exhausted all of its appeal rights *(RMC 9/15/14, p. 1)*. Only fee-for-service claims that were denied because they weren't considered medically necessary for inpatient admission are eligible. There's no cherry picking; if hospitals sign up for the settlement process, they accept 66% payment for all eligible claims and withdraw the appeals. That means claims are still technically denied, which has cost-report implications.

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With Gene Therapy on the Rise, Biosafety May Be an Item for Hospital Work Plans

The pioneering treatment at your hospital, where surgeons are injecting adenoviruses and retroviruses into glioblastoma brain tumors to induce an anti-tumor immune response, may not seem like something that belongs on your compliance risk assessment, but biosafety isn't just about reducing risk from infectious diseases and hazardous materials. It also requires oversight of emerging gene therapies. With biological risks coming at hospitals from all directions and after the 2014 Ebola near-miss pandemic, compliance officers may want to take a closer look at this area.

"Deficiencies in biosafety compliance can lead to serious risks to the institution, workers and the public," said Joan Robbins, Ph.D., senior vice president of biosafety and gene therapy at WIRB-Copernicus Group in Puyallup, Wash.

Biosafety doesn't seem to be getting the attention it deserves, Robbins said in a Nov. 1 webinar sponsored by the Health Care Compliance Association. Possibly it's because hospitals have risk fatigue. They have been preparing for a slew of potential catastrophes, including natural disasters, mass-casualty attacks, cyberterrorism and workplace violence. "There are so many competing risks," she noted.

Biosafety also tends to take a back seat to infection control for patients (see box, p. 3), Robbins said. "Nurses, pharmacy technicians and other health care workers may be exposed to biosafety risks. They're trained on infection prevention and control to protect patients, but not so much to protect themselves and the public. A comprehensive biosafety program needs to address all these issues and not focus exclusively on infection prevention for patients," she said.

continued

The risks posed by biosafety are growing for several reasons. There is the potential for the faster spread of infectious diseases because of international travel; the ongoing threat of bioterrorism — "anthrax is a continuing potential threat," Robbins said; the resurgence of old viral enemies, such as measles, "due to unvaccinated populations"; and the rise in antibiotic-resistant superbugs. Then there's the risk of contamination from new therapies if they are not handled in accordance with biosafety protocols, she said. The threat will multiply as more human gene transfer agents are approved. Already, viruses, including adenovirus, retrovirus, herpes simplex and lentivirus, are being used in gene therapy, Robbins said. The herpes virus is used to treat melanoma, adeno-associated viruses are deployed against inherited retinal diseases, and the polio virus also is being injected into glioblastoma brain tumors. "You can imagine the complexity of delivering a virus during brain surgery," Robbins said. "How many people are involved, and how many pieces of equipment could be touched, and how do you decontaminate them afterward?"

On the bacterial front, the genetic properties of listeria and salmonella are being modified to treat cancer. "They are attenuated so you don't infect anything but the tumor cells, but you don't want to accidentally expose immunocompromised cancer patients or patients who are pregnant," Robbins said. In chemotherapy infusion centers, patients often sit side by side in a row of chairs as the drip works its way through, which may be comforting for them. "If you're infusing a virus, it's better to have a separate room to make sure you clean it properly. You want to make sure you're not putting anybody at risk," she noted.

Biosafety compliance is enforced by several federal agencies. A lot of Occupational Safety and Health Administration (OSHA) regulations apply, Robbins said. They include 29 CFR 1910.1030 (exposure to bloodborne pathogens, such as hepatitis and HIV), 1910.134 (respiratory protections) and 1910.132 (the requirement to provide personal protective equipment). Hospitals that participate in certain clinical trials are subject to the National Institutes of Health (NIH) Guidelines for Research Involving Recombinant or Synthetic Nucleic Acid Molecules, and if they receive or ship hazardous materials for clinical trials, hospitals must comply with Department of Transportation hazardous materials regulations, Robbins said. Biosafety is also overseen by the Centers for Disease Control and Prevention and regulated by the states.

Reputation, Revenue Are on the Line

There's a lot at stake, and this became painfully clear during the Ebola crisis. Questions were raised about whether hospitals failed to train staff on the use of personal protective equipment (PPE), such as clothing, masks and goggles. A nurse, Nina Pham, contracted the Ebola virus while working at Texas Health Presbyterian Hospital in Dallas. She was infected after coming into contact with the first person in the United States to be diagnosed with the virus, and she sued the hospital, which resulted in a settlement for an undisclosed amount. "Only four of the thousands of hospitals in the United States had fully functional biocontainment units to deal with this type of infection," Robbins said. Since then, some institutions have put procedures in place to deal with emerging infectious diseases or the resurgence of diseases, "but patients will show up at all kinds of facilities — at your facility."

In addition to the financial damage, there is reputational harm in these cases, said Bret Bissey, senior vice president of compliance services at MediTract, at the webinar. "It can create a bomb in your organization, and you don't want that bomb going off."

Biosafety management is challenging in health care organizations because there are so many moving parts. "For an institutional biosafety program to be effective, you need cooperation," Robbins said. "Management

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needs to stress a culture of safety to get everyone to work together to ensure biosafety works." To find out where you stand, Robbins recommended performing a biosafety risk assessment.

There are two components:

(1) Document review: This includes a review of all administrative controls, training programs and biosafety policies, including the exposure control plan. "What happens if a health care worker is stuck with an infected needle? Who do they talk to? Do they have to talk to their immediate supervisor? There is a confidentiality issue around that," Robbins said. "This is an area where often there's a lot of need for improvement." She also suggested looking at biosafety and environmental health policies and training plans. Are there agent-specific PPE requirements or a general policy of "take the gloves and mask" if you need them? "There needs to be a specific analysis of threats that people will be exposed to and training on them," she said, in addition to general biosafety awareness training. Also review training records — "it's not good enough to train nurses if you haven't also trained janitorial staff that handles contaminated waste" — as well as waste management plans and safety certification documents.

(2) Facility review: "The facility review is meant to verify there is adequate containment of biological material," Robbins said. It involves an onsite review of any space where a biological material will be received, stored, manipulated, administered to patients and disposed of. "That touches a lot of areas of the institution or clinic," she noted. "There will be an analysis of all practices and procedures that impact biosafety." A number of areas — pharmacy, labs, clinics, unloading and loading areas and waste storage — should be evaluated for biosafety compliance. Are there emergency showers and eyewashes? Are the cabinets and floors easy to disinfect? Is there controlled access to storage? Are there signs alerting the public to biological materials? Do refrigerators have signs warning they contain biological materials? The facility's practices and procedures should be evaluated against best practices, including the Centers for Disease Control and Prevention's *Biosafety in Microbiological and Biomedical Laboratories, 5th Edition*.

Robbins described the results of reviews at two hospitals. One hospital was conducting a clinical trial with an experimental virus that could infect people if it were inhaled or contacted mucous membranes or transmitted through a needle-stick. Despite the risk to employees and other patients, there were no sinks in the prep room, no eye wash bottles and no biosafety cabinet, which meant the virus was prepared on an open bench. The chairs where patients were given the virus were covered in cloth, so they couldn't be properly cleaned, Robbins said. "Needles, vials and gloves were disposed of in the chemo waste rather than segregated as biohazardous waste," she said. "Waste was put in the hallway where anyone could have access." Training was outdated or missing. As a result, the hospital was at risk of receiving citations and/or fines from OSHA, NIH and the state, which regulates the disposal of biohazardous and medical waste.

The other hospital was using an approved virus, which could infect people if it came in contact with skin or mucous membranes. "They did a lot of things right," Robbins said. "The facility had all the right equipment, its surfaces were easy to clean, dressings were properly disposed of, and access to waste was properly controlled." The problem was with training, she said. "Staff

Understanding Biosafety Compliance vs. Infection Control

Compliance officers may want to add biosafety compliance — which is different from infection control — to their internal work plans (see story, p. 1), said Joan Robbins, Ph.D., senior vice president of biosafety and gene therapy at WIRB-Copernicus Group in Puyallup, Wash. Contact her at jrobbins@wcgclinical.com.

Biosafety	Infection Prevention & Control
• Required for the safe handling and containment of infectious or potentially infectious biological materials • Requires fundamental understanding of the biological material/agent • Agent-specific risk assessment and risk group classification • Dependent upon standard microbiological practices, safety equipment, and facility safe guards • Protects workers, the environment, and the community • Laboratory associated infections (LAIs)	• Required to prevent the transmission of communicable disease in all healthcare settings • Requires understanding of risk factors that increase patient susceptibility to infection • Patient-specific risk assessment • Dependent on type of patient-care activity • Dependent on underlying patient host immune system • Protects the patient • Healthcare associated infections (HAIs)
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had not been thoroughly trained on agent-specific biosafety issues." That includes the use of PPE, such as face shields, because this virus could affect the eyes if there were a splash. "This agent also comes with a warning that immunocompromised and pregnant staff should not be involved in its administration, so specific training needed to be implemented," she said. The hospital was at risk of citations and/or fines by OSHA and the Environmental Protection Agency.

Robbins believes it's often helpful to have an independent group conduct a biosafety assessment to "overcome institutional complacency or inter-department cooperation issues."

Contact Robbins at jrobbins@wcgclinical.com and Bissey at bbissey@meditract.com. ✧

Hospital Pays $5.65M to Settle CMP Case Over Modifiers -59, -91

Memorial Hermann Health System in Texas agreed to pay $5.65 million in a civil monetary penalty (CMP) settlement over its alleged misuse of modifiers -59 and -91.

The HHS Office of Inspector General (OIG) contends the health system submitted outpatient claims to Medicare, Medicaid and TRICARE "that automatically appended modifiers -91 and -59 to CPT codes" from Sept. 1, 2009, to Oct. 20, 2015, according to the settlement. Memorial Hermann, which is based in Houston, self-disclosed the billing errors to OIG and entered its Self-Disclosure Protocol on Jan. 6, 2016. There was no admission of liability in the settlement.

Modifier -91 is used on outpatient claims when lab tests are repeated on the same patient on the same date of service on a new specimen. Medicare will pay again if the lab test is medically necessary, but it's not appropriate to bill twice to confirm results or check whether the equipment is working properly, according to Medicare administrative contractor WPS.

Repeat lab tests come up in observation and outpatient surgery, says Valerie Rinkle, president of Valorize Consulting. For example, if the physician starts a patient on drug therapy, bloodwork may be repeated to determine if it's reached a therapeutic level. But the second test requires a new physician order and a new specimen for repeat billing, she says.

Modifier -91 shouldn't automatically be appended to a CPT code, says Rinkle. Labs may have standing orders to repeat tests every four hours, but they aren't medically necessary unless the standing order is confirmed for that patient by his or her treating physician and it supports the medical management of the patient, she says.

Life has gotten more complicated with modifier -59 since CMS introduced four replacement modifiers, but then hedged its bets *(RMC 12/15/14, p. 6)*. Modifier -59 — the most popular modifier — is appended to a CPT code when physicians perform a separate and distinct procedural service on the patient on the same day as another procedure that's *not* an evaluation and management service. The use of the modifier generates additional payment because it allows providers to bypass National Correct Coding Initiative edits that normally block a separate payment.

XU Modifier Requires 'High Alert'

Four -59 subtype modifiers took effect on Jan. 1, 2015, but CMS decided providers are free to use either -59 or the more specific "X" modifiers as they see fit. "It's open," Rinkle says. "You have a choice. Modifier -59 is fine. You can put it on codes that meet the criteria, or you can report the X modifiers in lieu of -59 or a combination." Think of the subtype modifiers as an audit tool; "you can critically use them to evaluate your use of modifier -59," Rinkle says.

The four subtype modifiers are:

◆ ***XE: Separate Encounter*** (a service that is distinct because it occurred during a separate encounter).

◆ ***XS: Separate Structure*** (a service that is distinct because it was performed on a separate organ/structure).

◆ ***XP: Separate Practitioner*** (a service that is distinct because it was performed by a different practitioner).

◆ ***XU: Unusual Non-Overlapping Service*** (a service that is distinct because it does not overlap the usual components of the main service).

Rinkle says coders should be "on high alert with the XU modifier because its correct use is not as evident as the other X modifiers." It's possible for -59 to be misused at hospitals that hard-code the modifier onto procedures in their chargemasters. Although that's a risky thing to do, "it can be legitimate if you have a very controlled charge-capture process and do very aggressive auditing and monitoring or use coders to double check every case and give them a way of removing the modifier and the separate code if it's not appropriate," she says. Some services typically performed in combination will require an evaluation for the use of modifier -59, including drug administration, to determine whether it's separate or integral to a procedure and can be separately billed with modifier -59.

In a statement, Hermann Memorial said its corporate compliance team "was made aware of the issue and immediately launched an internal audit that led to our voluntary disclosure" to OIG. Consequently, the health system "implemented additional safeguards and in-

creased compliance resources to further strengthen the integrity of our billing processes. Through this, we were pleased to see the effectiveness of our Corporate Compliance program."

Contact Rinkle at valerie.rinkle@valorizeconsulting.com. ✧

In Compliance Training, CCO Uses Many Methods; Metrics Are Key

The 14,000 employees at Legacy Health in Portland, Ore., are slowly receiving new "badge stuffers," which are cards with compliance reporting information that can be tucked in the laminated badges they wear around their necks or clipped to their uniforms. The cards list the number of the compliance hotline and HR call center and briefly explain how to report concerns. It's one way that Chief Compliance Officer Shannon Kennedy keeps compliance in front of employees.

"Every employee and vendor must wear their badge at all times, and the badges are designed with a plastic sleeve. The badge stuffers can be easily placed in the same sleeve and serve as an instantaneous resource for any person who wants to report concerns," said Kennedy, who spoke Oct. 18 at the Best Healthcare Compliance Practices Forum sponsored by the Health Ethics Trust. The badge stuffers are distributed at orientation and annual compliance training sessions and by compliance committee members to their departments.

Kennedy said compliance training must come at employees from many different directions, and it should be measured to determine what grabs their attention — not just whether they complete the required education session (see box, below).

Here are the four elements of her education program:

(1) An annual education plan: It describes exactly who will be trained on what and how often. For example, new employee orientation covers all aspects of Legacy's compliance program, is in person and lasts 40 minutes. The board audit committee receives 40 minutes of in-person training semi-annually. The same goes for Legacy leadership.

(2) Multiple training formats: Legacy uses a combination of in-person training, online training, email blasts (e.g., with quotes on integrity from Justice Potter Stewart and Martin Luther King Jr.), badge stuffers and compliance articles in three employee newsletters (a monthly newsletter for nurses, a monthly newsletter for physicians and a weekly newsletter from public relations). Recent articles have included "A Serious HIPAA Risk: When an Employee is Also a Patient," "Social Media Dos and Don'ts" and "Retrospective Medical Record Access."

(3) Metrics: "Compliance officers really struggle with measuring the effectiveness of education," but there are

Improving Compliance-Training Effectiveness: Questions to Consider

Here are questions for compliance officers to think about as they evaluate the impact of their training on employees. It was developed by Tony Capullo, president of Professional Provider Services in Fort Lauderdale, Fla. Contact him at acapullo@ppsgroup.org.

1. Knowledge retention – How well does the staff retain information?
2. For a hospital using a learning management system (i.e., tracking and documenting the training with technology), what internal controls are in place to prevent sharing or exchanging of usernames and passwords?
3. For hospitals using a learning management system, can staff fast forward or skip modules?
4. How does the organization assess gaps in employee knowledge and competence? (Pass/fail rates)
5. What is the frequency of the training?
6. Are there multiple delivery methods?
7. Are the training techniques flexible/engaging enough to accommodate the different needs of employees?
8. Is the training appropriate for different risk profiles across staff and structure?
9. Can the training program be audited?
10. Is the training practical and relevant to the day-to-day work of employees and illustrative of the industry?
11. How often is the training reviewed, updated and refreshed for effectiveness?
12. Is the training recorded?
13. Is staff certified on the various aspects of compliance?
14. Does the corporate culture correspond to the training? (Is the Board endorsement communicated to the whole organization?)
15. Does the organization leverage the use of technology?
16. Is there a blend of technology and face-to-face interaction?

certain things they can do, says Kennedy. In addition to tracking the completion of the education plan and running reports on the completion of mandatory online education, Kennedy partners with the marketing and IT departments to quantify readership metrics. "You can track page views" of compliance articles on the intranet page, she says. "You run reports on the unique URLs. If an article is specific to HIPAA, it tells you whether the article is popular. It's a marketing strategy, and it drives readers to the compliance website." Board members are enthusiastic about readership metrics for compliance website hits and compliance articles, Kennedy says. She also is working with the human resources department to gather data from employees as part of Legacy's effort to evaluate the effectiveness of orientation. Using Likert-scale survey questions, which are the most popular approach to survey research, they are asking new hires how effectively the orientation explained the most important aspects of the compliance program; HIPAA rules and Legacy policies as they relate to patient privacy; and ways to protect electronic health information.

(4) Senior leadership support to set the tone from the top: At Legacy, employees and physicians are most receptive to compliance articles written by the C-suite executives. The chief nursing officer recently wrote a compliance article for the monthly nursing newsletter on social media, which was the most read article for the year. Legacy also has a video for new employees with a message from the CEO and Kennedy on the importance of compliance.

Contact Kennedy at sakenned@lhs.org. ✧

HHS, AHA Battle Over Medicare Appeals Backlog Heats Up

In the Medicare appeals backlog case before the U.S. District Court for the District of Columbia (*Burwell v. American Hospital Association*, No. 14-cv-00851), both parties have now filed motions and responses over whether the court should issue a writ of *mandamus* compelling CMS to resolve the backlog on a court-ordered schedule.

In September, Judge James Boasberg denied HHS's motion to stay the proceedings until Sept. 17, 2017, saying there appeared to be "equitable grounds for *mandamus*." He ordered the plaintiff, the American Hospital Association (AHA), to file the formal request for the writ, and the defendant, HHS, to respond by early November. In its motion for summary judgment formally requesting

CMS Transmittals and *Federal Register* Regulations

Nov. 11 – Nov. 17

Live links to the following documents are included on *RMC*'s subscriber-only Web page at www.AISHealth.com. Please click on "CMS Transmittals and Regulations" in the right column.

Transmittals

(R) indicates a replacement transmittal.

Pub. 100-04, Medicare Claims Processing Manual

- Changes to the Laboratory National Coverage Determination Edit Software for January 2017 (R), Trans. 36256CP, CR 9806 (Nov. 16; eff. Oct. 1; impl. Dec. 5, 2016)

Pub. 100-20, One-Time Notification

- Adding a Foreign Language Tagline Sheet to Medicare Summary Notices (R), Trans. 17510TN, CR 9617 (Nov. 16; impl. by Dec. 5, 2016)

Federal Register Regulations

Final Regulations

- Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Procurement Organization Reporting and Communication; Transplant Outcome Measures and Documentation Requirements; Electronic Health Record Incentive Programs; Payment to Nonexcepted Off-Campus Provider-Based Department of a Hospital; Hospital Value-Based Purchasing Program; Establishment of Payment Rates Under the Medicare Physician Fee Schedule for Nonexcepted Items and Services Furnished by an Off-Campus Provider-Based Department of a Hospital, 81 Fed. Reg. 79562 (Nov. 14, 2016)
- Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements, 81 Fed. Reg. 80170 (Nov. 15, 2016)
- *Correction*: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements (Fed. Reg. pub. date, Nov. 18, 2016)
- Medicaid: Covered Outpatient Drug; Delay in Change in Definitions of States and United States, 81 Fed. Reg. 80003 (Nov. 15, 2016)
- *Correction*: Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers; Correction, 81 Fed. Reg. 80594 (Nov. 16, 2016)

Notices

- CY 2017 Inpatient Hospital Deductible and Hospital and Extended Care Services Coinsurance Amounts, 81 Fed. Reg. 80060 (Nov. 15, 2016)
- CY 2017 Part A Premiums for the Uninsured Aged and for Certain Disabled Individuals Who Have Exhausted Other Entitlement, 81 Fed. Reg. 80071 (Nov. 15, 2016)
- Medicare Part B Monthly Actuarial Rates, Premium Rate, and Annual Deductible Beginning January 1, 2017, 81 Fed. Reg. 80063 (Nov. 15, 2016)

mandamus relief, AHA asked the court to order HHS to implement three sets of "practicable solutions: "(1) offer reasonable settlements to broad groups of Medicare providers and suppliers; (2) delay repayment of at least some subset of disputed Medicare claims, and toll the accrual of interest on those claims for waiting times beyond the statutory maximums; and (3) impose financial penalties on recovery audit contractors (RACs) for poor outcomes at the administrative law judge (ALJ) level."

In its response, HHS again asked the court not to issue a writ of *mandamus* and provided specifics on the progress the agency is making in resolving the backlog, projecting that "with Congressional action, the backlog will continue to decrease until it is eliminated completely by the end of fiscal year (FY) 2019, two years earlier than it previously projected." The agency also cited as a "significant change" the fact that RAC appeals accounted for only 9.5% of appeals filed with the Office of Medicare Hearing and Appeals in FY 2016, compared with 50.3% in FY 2013. If the court issues the writ, HHS said, "it should craft an order of remedies that does not conflict with statutory restrictions on the Medicare program and does not jeopardize the Medicare Trust Funds." The plaintiff's proposed remedies, the agency argued, do not meet these standards.

In its response filed on Nov. 14, AHA again maintained that HHS's proposed remedies only preserve the status quo and ignore "the severity of the problem and the clarity of the statute." The court has not ruled on the plaintiff's motion and HHS's response. ✧

New Appeals Settlement Pays Less

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"It may make business sense to clean up the old cases," says Jessica Gustafson, an attorney with The Health Law Partners in Southfield, Mich. "There is an opportunity for relief in the Medicare appeals process," but it usually takes years, "and there really are time value considerations here."

This time around, "CMS made a series of improvements to reduce the burden and expedite the process," said Tracy Richardson, deputy director of the Financial Services Group, on the call. Hospitals first submit an "expression of interest" to CMS, said Casey Welzant, health insurance specialist in the Financial Services Group. In response, CMS will send them an administrative agreement and a spreadsheet of eligible claims that it believes qualify for partial payment. That's a big difference from before: Last time, hospitals generated the list of eligible claims, and there was some wrangling with Medicare administrative contractors over whether claims should be added or deleted from the list.

"If they agree with all the claims, they sign the administrative agreement" and return it within 15 days, Welzant said. CMS will assume hospitals "abandoned" the process if they miss the deadline, she explained, although the agency will attempt to follow up with hospitals. Seven to 10 days after receiving a hospital's information, CMS will sign the administrative agreement, and within 180 days of the signature, hospitals get paid.

No Dice if There's an Investigation

If hospitals find "discrepancies" on the spreadsheet, they have the option of completing an eligibility determination request. The deadline for submitting that to CMS is 15 days after receiving the administrative agreement.

If hospitals are the subject of a False Claims Act or other investigation, they may be excluded from the settlement process, Welzant says. "If that's the case, hospitals will be notified ASAP after [CMS] gets the expression of interest," she says.

As they decide whether to jump onto the settlement bandwagon, hospitals have some things to consider, Gustafson says. If they stick to their appeal guns, they may win at the ALJ or Medicare Appeals Council level and get 100% reimbursement, or they could lose it all. Either way, the answer won't come fast. The appeals backlog at the Medicare Office of Hearings and Appeals (OMHA) is alive and well, Gustafson says. According to OMHA's fiscal year 2017 report on justifications for estimates for the appropriations committee, the average processing time for cases was 661 days in 2015, and it had increased to 935 days as of October 2016.

"If we are looking at cases prior to Oct. 1, 2013, you have already been waiting for a pretty long time," she says. "I would encourage providers to take a look at the numbers and see if it makes business sense." And prospects for winning appear to be dimmer. The percent of fully favorable decisions for providers has dropped precipitously, from 63% in 2010 to 28.4% in March 2016, HHS said in a May 25 filing in the ongoing court battle with the American Hospital Association over the

Medicare appeals backlog *(RMC 9/26/16, p. 8; 2/15/16, p. 6)*.

One compliance officer whose hospital did the first round of the appeals settlement process was glad it did. "We would participate again, if we had to do it over. I hate to give up [appeals], just based on principle, but it seemed like the best decision," says the compliance officer, who asked not to be identified. "It brought the revenue in now rather than waiting years for the unknown."

Another compliance officer, Shannon Kennedy, chief compliance and privacy officer for Legacy Health in Portland, Ore., was pleased with the first settlement process and thought it went smoothly. "I think of it as a good business decision to choose your battles," she says. But there was the same uneasy feeling about the deal. "Philosophically, having to settle a claim that should not have been denied to begin with is very frustrating. We're backed in a corner: Either we appeal and wait a gazillion years to see if we win with an ALJ who may or may not know anything about health care or cut our losses and get 68%," Kennedy says.

Visit the CMS website on the settlement at http://tinyurl.com/p9ha9qh. Contact Gustafson at JGustafson@thehlp.com and Kennedy at sakenned@lhs.org. ✧

NEWS BRIEFS

◆ **CMS's new strategy for program integrity — the unified program integrity contractors (UPICs) — is now underway,** speakers said at a Finally Friday webinar on Oct. 21 sponsored by the Appeal Academy. UPICs are replacing zone program integrity contractors (ZPICs), program safeguard contractors, the Medicare-Medicaid data match program and Medicaid integrity contractors (MICs), but reviews by Medicare administrative contractors (MACs) and recovery audit contractors will continue. A CMS spokesman tells *RMC* that in October, CMS announced the award of the UPIC contract for the Northeast jurisdiction, which includes Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Delaware, Pennsylvania and Maryland, to SafeGuard Services. The Midwest jurisdiction UPIC contract was awarded earlier this year. The seven ZPIC zones and five MIC jurisdictions are being consolidated into five UPIC jurisdictions to align with the MACs *(RMC 4/7/14, p. 1)*.

◆ **Zwanger & Pesiri Radiology Group, Zwanger Radiology P.C. and Steven Mendelson, M.D., will pay $8.153 million to settle false claims allegations,** the New York State Attorney General (AG) and the U.S. Attorney's Office for the Eastern District of New York said Nov. 17. The settlement resolves allegations that from Jan. 1, 2003, to Oct. 26, 2015, the defendants billed Medicare and Medicaid for services provided or supervised by physicians who weren't enrolled in Medicare. The settlement also resolves allegations that Zwanger submitted false claims for certain radiology procedures, including ultrasounds, that weren't ordered by a treating physician between Jan. 1, 2008, and Feb. 28, 2014, according to the AG's office. Visit http://tinyurl.com/hnb7oqf.

◆ **In an Emergency Medical Treatment and Labor Act (EMTALA) case (*Friedrich v. South County Hospital Healthcare System*, C.A. No. 14-353 S), the U.S. District Court for the District of Rhode Island has denied South County Hospital Healthcare System's motion for partial summary judgment.** The hospital argued that EMTALA did not apply to its Urgent/Walk-in Care facility. Patricia Friedrich had gone to the facility fearing a heart attack and "was diagnosed with gastroesophageal reflux disease, given a 'GI cocktail' and discharged with no follow-up ordered." The next day she was found unresponsive and subsequently died. The plaintiff, the patient's husband, maintained that the facility did not give his wife an EMTALA-required screening to determine whether she had an emergency medical condition. "The threshold question in this case is whether the Urgent/Walk-in Care is a 'dedicated emergency department' of South County Hospital under EMTALA," according to Chief Judge William E. Smith. He found that under EMTALA, the Urgent/Walk-in Care qualified as a dedicated emergency department because it held itself out to the public "as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment." South County pointed out that its website stated that the Urgent/Walk-in Care offers "urgent" but "non-emergency" care; however, the judge ruled that South County "cannot disclaim the responsibility that comes from presenting itself as an urgent care center." Visit http://tinyurl.com/hxos9ol.

◆ **The HHS Office of Inspector General (OIG) has posted its annual report on the *Top Management and Performance Challenges Facing HHS*.** Visit http://go.usa.gov/x8TqR.

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